Chapter 6
PPIP Procedures

PPIP Materials

All adults age 18 and older should receive annual comprehensive health risk assessment services as part of their routine health care. The PPIP system of the U.S. Public Health Service, Department of Health and Human Services provides clinical settings with tools that allow the clinical staff to facilitate the delivery of preventive care. This chapter will describe the purpose and procedures for use of each of the tools/forms found in the PPIP kit.

For the Primary Care Team

- Clinician's Handbook of Preventive Services
- Health Risk Profile (Texas only)
- Adult Preventive Care Flow Sheets
- Post-it Notes
- Prevention Prescriptions
- Reminder Postcards
- Posters and Charts
  - Waiting Room Poster
  - Adult Preventive Care Timeline Chart

For the Patient

- Personal Health Guide

Clinician's Handbook of Preventive Services

Purpose

To serve as a resource/reference for clinicians and staff for the delivery of preventive care.

Background

One of the barriers to providing comprehensive clinical preventive services has been the lack of a resource for preventive care guidelines. In 1989, the U.S. Preventive Services Task Force, a body of experts convened by the U.S. Department of Health and Human Services, examined the scientific evidence for almost every type of preventive care and published the Guide to Clinical Preventive Services. In 1994, the U.S. Department of Health and Human Services, Public Health Service, issued its first comprehensive set of recommendations in the Clinician's Handbook of Preventive Services. The recommendations of major authorities regarding who should receive each type of preventive service and the basics of delivering each service are summarized in the Handbook.

The Clinician's Handbook of Preventive Services may be used to both create a protocol for preventive care and as a user-friendly treatment room tool.

Procedures for Use

In each chapter, this book provides valuable information on preventive care such as:

1) Recommendations from major authorities about who should receive the preventive service;
2) Practical descriptions of how to deliver the preventive services (e.g., Pap smear, smoking cessation, counseling, hepatitis vaccination); and
3) A listing of available patient education resources.

The Clinician's Handbook is divided into four main subject areas:

1. Basic information on concepts of prevention and implementing preventive care;
2. Specific preventive care topics for children and adolescents;
3. Specific types of preventive care for adults and older adults;
4. Appendices that provide a list of major authorities cited and tables that summarize disorders according to specific risk factors.

Health Risk Profile

The Health Risk Profile (HRP) is a tool developed by the TDH Adult Health Program. It is used to identify if an adult patient's age, sex and/or personal health behaviors put him/her at risk for cardiovascular disease, diabetes, certain types of cancer, certain infectious diseases, and areas impacting personal safety.

General Instructions

The HRP should be completed as part of a comprehensive health assessment once each year for all patients who are at least 18 years old.

> Helpful Hint
> The HRP is a tool to aid in risk assessment and does not cover all possible risk factors. Therefore, use your professional judgment in assessing an individual's risk. These forms were developed by the Texas Department of Health and are not part of the federal PPIP kit. However, many staff have found them to be useful, either when used "as is", or when modified (recommended) based on the individual needs of the clinic/patients.

Procedures for Use

1. Complete the patient's demographic information.

2. For each of the topics listed on the HRP, read (or for the Self-Administered HRP, have the patient read) the potential risk factors for each topic. If any of the specific risk factors apply, indicate those by placing a mark by the appropriate risk factor. If at least one risk topic is applicable, the **Y** should be circled for that topic to indicate that a risk was identified. If none of the risks are applicable, circle the **N** to indicate that no risk was identified. Caution: If this section is left blank, it will appear that risk was not assessed.

3. See the Adult Health Program Manual for additional instructions for using this form. See Appendix B of this guide for additional sample forms.

Example

HRP Question—Mammography: You have a female patient who is 30 years of age. You want to know if she needs a mammogram. When you look at the HRP-SF, you note that a mammogram is recommended by the USPSTF only for women over 50 years of age. In this case, you do not need to mention the other risk factor (1-2 years since last exam) because of your patient's age. You would circle the **N** next to this topic and move on to the next question.

Note: The age for beginning screening and the intervals between any test/exam should be established by each clinic through a formal policy and the HRP should then be revised, if necessary, to reflect that policy. And, as always, the decision to perform any screening test or exam is based upon individual patient needs and clinical discretion.

> Helpful Hint
> In order to record the patient's well-woman care, you could also take this opportunity to post the date of her last Pap smear and results on the Flow Sheet.

4. An exception to indicating specific risk factors is the question concerning STDs/HIV. In order to be sensitive to the patient's feelings and to encourage an honest answer, it is preferable not to identify specific risk factor(s). You should first read, or have the patient read, all of the risk factors (e.g., history of sharing drug needles, male-to-male sex, history of STDs, or multiple sex partners). Then ask if any of the risk factors mentioned are applicable to him/her. If the patient indicates a risk, circle the **Y** next to this question. STD risk and HIV status can then be explored further by the clinician.

5. During the year following the health assessment visit, all patients who are at risk for any of the risk factors must receive the appropriate screening, exam/tests, education/counseling (at least once), referral, and follow-up based on the guidelines provided in the Clinicians's Handbook of Preventive Services or those established by your facility.

Health Risk Profile

Ethnicity: *(circle one)*
(W) White, not of Hispanic origin
(H) Hispanic
(A) African American, not of Hispanic origin
(NA) Native American
(P) Asian / Pacific Islander
(o) Other

Name: _____ Date of Visit: _____

Date of Birth: _____ Age: _____ Male _____ Female _____ I.D. or S.S.#: _____ Clinic: _____ Clinician: _____

At Risk

Y N 1. **Weight**
q above healthy weight range (see chart on back)

Y N 2. **Blood Pressure** (see chart on back)
q a) B.P. ≥ 140/90 mm/Hg
q b) personal history of high blood pressure
q c) family history (first-degree relative)
q d) above healthy weight range
q e) lack of exercise

Y N 3. **Cholesterol**
q a) > 5 years since last normal screen or cholesterol test or never done
q b) > 1 year since previous abnormal test
q c) high Risk for CHD: (see chart on back)

Y N 4. **Immunization**
q a) > 10 years since last Td
q b) ≥ age 65 and has not yet received pneumococcal vaccine
q c) ≥ age 65 and has not had flu vaccine if it is flu season

Y N 5. **Oral Health Care**
q a) does not brush daily
q b) does not use dental floss daily
q c) does not limit sweets, especially between meals
q d) smokes or chews tobacco products

Y N 6. **Breast Exam**
q a) age 20-39 and > 3 yrs. since last clinical breast exam
q b) ≥ age 40 and > 1 yr. since last clinical breast exam
q c) does not examine breasts monthly

Y N 7. **Mammogram:** ACS recommends: women 40-49 years of age receive a screening mammogram every 2 years and women age 50 and older receive a screening mammogram annually.
q Not up to date with ACS standards

Y N 8. **Pap Smear:** ACS recommends: annual Pap smear at onset of sexual activity. If 3 or more satisfactory, normal, annual exams, the Pap may be performed every 1-3 years.
q a) Not up to date with ACS standards
History of any of the following:
q b) genital warts
q c) sexually transmitted disease
q d) multiple sex partners
q e) abnormal Pap smears

Y N 9. **Testicular Exam**
q male age 15–35 years and a history of atrophic or undescended testicle

Y N 10. **Skin Exam**
q a) has family history of skin cancer
q b) frequent sun exposure

Y N 11. **STD/HIV:** The following are risk factors for STD's such as HIV, syphilis, gonorrhea, and chlamydia. Answer yes if any of these apply to you. (Do not need to specify which risk factor client has.)
q a) history of injecting drug use (IDU)
q b) male to male sex
q c) history of STD
q d) multiple sex partners

Y N 12. **Tuberculosis Test:** Has one of the following risk factors and has not had a T.B. test in 1 yr.:
q a) alcoholic
q b) health care worker
q c) exposed to someone with T.B. and has not been screened since exposure
q d) recently moved from Asia, Africa, Central or South America, or the Pacific Islands
q e) kidney failure
q f) HIV infection

Y N 13. **Glucose Test/Diabetes**
q a) personal history of diabetes
q b) family history of diabetes (first-degree relative)
q c) diabetes during pregnancy
q d) above healthy weight range
q e) Native American, Hispanic or African-American

Y N 14. **Smoking**
q currently smokes

Y N 15. **Physical Activity**
q does not exercise at least 30 minutes / 3 times per week

Y N 16. **Nutrition**
q a) above healthy weight range
q b) does not eat 5 fruits or vegetables per day
q c) high fat in diet
q d) excess sugar in diet
q e) excess salt in diet

Y N 17. **Safety**
q a) does not always wear seatbelts while in car
q b) drives after drinking or rides with a driver who has been drinking
q c) has gun and ammunition in same place (loaded or unloaded)
q d) does not have smoke detectors in home

Y N 18. **Family Planning**
q Not ready to have a child, and does not use birth control

Y N 19. **Alcohol and Drug Use**
q a) For women: are you pregnant and do you drink alcohol or use drugs
q b) ever felt you ought to cut down on drinking or drug use
q c) people ever annoyed you by criticizing your drinking or drug use
q d) ever felt bad or guilty about your drinking or drug use
q e) ever had a drink first thing in the morning to steady your nerves or get rid of a hangover

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Blood Pressure Screening Guidelines

Initial Screening Blood Pressure (mm Hg)*		Follow-up Recommended**
Systolic	**Diastolic**	
<130	<85	Recheck in 2 years
130-139	85-89	Recheck in 1 year***
140-159	90-99	Confirm within 2 months
160-179	100-109	Evaluate or refer to source of care within 1 month
180-209	110-119	Evaluate or refer to source of care within 1 week
•210	•120	Evaluate or refer to source of care immediately

* If the systolic and diastolic categories are different, follow recommendations for the shorter time follow-up (e.g., 160/85 mm Hg should be evaluated or referred to source of care within 1 month).
** The scheduling of follow-up should be modified by reliable information about past blood pressure measurements, other cardiovascular risk factors, or target-organ disease.
*** Consider providing advice about lifestyle modifications.

The Fifth Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure, National Institute of Health, January 1993, NIH Publication No. 93-1088.

Standard for Adult Health Program

Healthy Weight Chart

Height*		Females**	Males***
4'10"	(58")	95-130	100-130
4'11"	(59")	95-130	105-135
5'	(60")	100-135	110-140
5'1"	(61")	105-140	110-145
5'2"	(62")	105-145	115-150
5'3"	(63")	110-150	120-155
5'4"	(64")	115-155	125-160
5'5"	(65")	115-160	125-165
5'6"	(66")	120-165	130-170
5'7"	(67")	125-170	135-175
5'8"	(68")	130-175	140-180
5'9"	(69")	130-180	140-185
5'10"	(70")	135-185	145-190
5'11"	(71")	140-195	150-195
6'	(72")	145-200	155-200
6'1"	(73")	145-205	160-210
6'2"	(74")	150-210	165-215
6'3"	(75")	155-215	170-220
6'4"	(76")	160-220	170-225

* Without shoes
** From the healthy BMI range of 19.1 to 27.3 derived from three reference populations: the 1959 and 1983 Metropolitan tables and NHANES II.
*** From the healthy BMI range of 20.7 to 27.8 derived from three reference populations: the 1959 and 1983 Metropolitan tables and NHANES II.

Texas Department of Health 7/93
Public Health Nutrition Services Program

NCEP II Guidelines

CHD Risk Factors

"High Risk" is defined as two or more CHD Risk Factors:

H Age
Men • 45
Women • 55 or premature menopause without estrogen replacement therapy
H Family history of premature CHD:
Definite myocardial infarction or sudden death before age 55 in father or other male first-degree relative, or before age 65 in mother or other female first-degree relative.
™ Current cigarette smoking
™ Hypertension (• 140/90) or taking antihypertensive medication
™ HDL Cholesterol < 35 mg/dl
™ Diabetes mellitus

(™ = Modifiable risk factors)

If HDL is • 60 mg/dl, subtract one risk factor

Adapted from the Summary of the Second Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel II), JAMA, 1993; 269:3015-3023.

Adult Preventive Care Flow Sheet

Purpose

The Adult Preventive Care Flow Sheet can assist the clinician and staff to monitor and document counseling/education, examination/tests and immunizations provided to a patient based on the risks identified on the Health Risk Profile and the protocols provided in the Clinician's Handbook of Preventive Services, or adopted by your facility. It is also a useful communication tool for patient care staff.

Proper use of the Flow Sheet will allow you to identify:

- What services have been provided and when;
- What services have been ordered and when;
- What results are still pending and might need to be followed up; and
- What results were returned abnormal.

General Instructions

The Flow Sheet is to be initiated when the patient receives an annual risk assessment with appropriate screening, examination/tests, education/counseling, and immunizations. It is updated during the following year each and every time education and counseling is provided, and anytime a test or examination is completed (or results received).

The Flow Sheet is used in conjunction with the Health Risk Profile. Any topic on the HRP for which a **Y** has been circled under the "At Risk" column must be addressed in the appropriate area of the Flow Sheet.

Procedures for Use

1. Demographic Information

Complete the patient's demographic information and I.D. number.

Note: The revised AHP Flow Sheet in this section of the guide corresponds to the HRP-SF. If modifications are made to the HRP, the Flow Sheet must also be modified.

2. Counseling

This section lists each of the topics found on the HRP form. Each topic for which the patient is identified to be at risk on the HRP should be marked on the flowsheet. The patient must be counseled on each of these risks at least once during the following year. (See "Helpful Hint" below)

If this is a returning patient, ask if he/she brought the Personal Health Guide. If this is the patient's first PPIP assessment, issue a Personal Health Guide and instruct the patient briefly about its use (many sites have found this task is best performed by the front office staff). Use the information in the Personal Health Guide as you counsel the patient. Be sure to include the date the education and counseling is provided and by whom beside the corresponding topic on the flow sheet.

The section of the flowsheet reserved for documentation of education and counseling allows you to record and monitor the counseling provided to the patient over time.

> Helpful Hint
> Due to time limitations, patient readiness, ability to absorb the information, etc., a patient may not receive counseling for every identified risk during any one visit. A method should exist (e.g., use of Post-it Notes) to cue staff to conduct and reinforce any necessary counseling at the next visit and every visit thereafter, no matter how brief, until counseling has been provided for all identified risks at least one time.

3. Examination/Test Schedule and Results

The first column lists the exams/tests that may be required for each patient (determined by clinic policy, standing orders, clinician judgement, etc.).

The second column lists the frequencies at which these exams/tests should be performed (test frequency is determined as above).

The remaining columns should be completed as the tests are performed. The date should correspond to the date the test was performed or refused. The result can be coded as follows*:

N = Normal result
A = Abnormal result
R = Patient refused to have test/exam/immunization done (include date offered)
P = Test/exam/immunization has been ordered or is pending (e.g., flu shot due in the fall), or test/exam was performed or referred and results are not on chart (e.g., mammogram).
* Many sites have found it more helpful to record the actual result.

4. Immunizations

The first column lists immunizations for adults. Which immunizations to provide is determined by individual clinic policy, standing orders, clinician judgement, patient needs, etc.

The second column lists the frequency at which the immunizations should be given. (Frequency is determined as above).

The next column is available to record lot numbers, manufacturer's name or other vaccine I.D., etc. (revised Flow Sheet only).

The remaining columns should be completed as the immunizations are given. Fill in the date the immunization was given, the site of the injection and the initials/signature of the person administering the immunization (progress notes or an immunization form should be used if the information is too extensive for the available space).

> Helpful Hint
>
> To save staff time during the patient encounter, you should use the Flow Sheet from the previous year as the starting point for a new HRP when the patient returns for an annual health risk assessment. Many questions on the HRP can be answered prior to the visit by taking information from the Flow Sheet and elsewhere in the chart. "Pre-screening" is a key factor is the success of PPIP and should be done the day before the visit. Experience has shown that screening the charts on the day of the visit is less effective and frequently results in little or no pre-screening at all thus making prevention cumbersome and frustrating for staff and clinicians.

5. Referrals

To better assist clinicians and office staff in tracking preventive services, refer rals should be recorded in the last section of the flow sheet.

Adult Preventive Care Flow Sheet

PUT PREVENTION INTO PRACTICE

Name _____

Clinician _____

ID or S.S. # _____

Sex M___ F___ D.O.B. _____

Circle if counseling needed and/or action to be taken.

1. Weight
2. Blood Pressure
3. Cholesterol
4. Immunizations
5. Oral Health Care
6. Breast Cancer/BSE
7. Mammogram
8. Pap Test
9. Testicular Exam
10. Skin Exam
11. STD/HIV
12. Tuberculosis
13. Diabetes
14. Smoking
15. Physical Activity
16. Nutrition
17. Safety
18. Family Planning
19. Alcohol and Drug Use
20. _____
21. _____
22. _____

	Counseling provided (enter number of risk factor from list at left)			
Returned with Personal Health Guide				
Year				
Age				
Date				
Type(s)				
Date				
Type(s)				
Date				
Type(s)				
Date				
Type(s)				

Suggested Result Codes: O = Ordered N = Result Normal A = Result Abnormal R = Refused E = Done Elsewhere

Examination/Test	Schedule					
1. WT / HT	annually	Date / Result	☐	☐	☐	☐
2. Blood Pressure	q. 2 yrs. if < 130/85 (it is strongly encouraged to measure at q. clinic visit)	Date / Result	☐	☐	☐	☐
3. Cholesterol	q. 5 yrs. for age ≥ 20 if last screen normal q. yr. if previous abnormal	Date / Result	☐	☐	☐	☐
4. Breast Exam	q. 3 yrs. age 20-39 q. yr. ≥ age 40	Date / Result	☐	☐	☐	☐
5. Oral Exam	1. 1 yr. if at risk	Date / Result	☐	☐	☐	☐
6. Mammogram	q. 1-2 yrs. for women age 40-49 q. yr. for women age ≥ 50	Date / Result	☐	☐	☐	☐
7. Pap Smear	Annual at onset of sexual activity. If 3 or more satisfactory normal annual exams, may be performed q. 1-3 yrs.	Date / Result	☐	☐	☐	☐
8. Testicular Exam	Clinician's discretion	Date / Result	☐	☐	☐	☐
9. Skin Exam	q. 1 yr. if at risk	Date / Result	☐	☐	☐	☐
10. Plasma Glucose	q. 3 yrs. (or more frequently, at the discretion of the clinician)	Date / Result	☐	☐	☐	☐
		Date / Result	☐	☐	☐	☐

Immunizations

Tetanus-diphtheria	q. 10 yrs.	Date	☐	☐	☐	☐
Pneumococcal	> 65 yrs.	Date	☐	☐	☐	☐
Influenza	q. yr. > 65 yrs.	Date	☐	☐	☐	☐
P.P.D.	clinician's discretion	Date	☐	☐	☐	☐

Form No. AH-2 N (3/95)

Post-It Notes

Purpose

The Post-it Notes can be used to alert the nurse or clinician to needed preventive services such as screening exams, immunizations, and/or education and counseling.

Procedures for Use

A staff member reviews the patient's chart the day before his/her visit, including the completed HRP and Flow Sheet from the previous year(s), and places a Post-it Note on the chart in a conspicuous place if a screening exam/test appears due. The note will alert the clinician to consider the indicated preventive care. The note should be removed from the patient's chart after provision of the specific preventive service.

> Helpful Hint
> One site really liked using the Post-it Notes, but thought they weren't noticeable enough. So instead of using the PPIP Post-it Notes, they made their own from large bright fuchsia sheets that are clipped to the front of the chart. Another site uses the notes to provide positive feedback to staff, as well.

Prevention Prescriptions

Purpose

The prevention prescription can be used in many ways. Below are just a few:

- As reinforcement of discussion between the clinician and the patient concerning preventive health plans for the patient.
- As a "contract" between provider and patient to strengthen sense of commitment by both parties.
- As an "official" doctors' order.
- As individualized educational information the patient can take home and refer back to for reinforcement of the educational message.

Procedures for Use

At the completion of the patient visit, the clinician and the patient discuss and agree upon the types of preventive health care activities the patient can perform, such as smoking cessation or exercise. These activities are recorded on the prevention prescription form by the clinician. The prescriptions can be printed with carbonless duplicate sheets so that a copy of the instructions given to the patient can be retained for the patients' record.

Reminder Postcards

Purpose

The reminder postcards serve as a cue for patients to return to the clinic for specific screening tests, immunizations, follow-up, or the annual assessment.

Procedures for Use

Ideally, the postcards are completed by the office staff at the time the patient is in the clinic. The cards can be kept in a 5" x 8" file box for storage. A month before the patient is to return for a visit, the postcards should be mailed to him/her. To assure the patient's privacy, fold and staple or tape the card before mailing.

Helpful Hint

A simple "tickler" file may be created by having the patient address a card at the time of the visit. Staff then file it under the month in which the next preventive service is needed. Reminder postcards are mailed at the beginning of each month. Or, they may be sent at the end of each month only to those patients who have not yet made an appointment. Some clinics use the patient's birthday for scheduling the annual assessment. This may help the patients and staff remember to schedule a yearly appointment.

Posters and Charts

Purpose

Prevention-oriented posters and charts serve as a reminder for clinicians and as a reinforcement and educational tool for patients.

Procedures for Use

The **Waiting Room Poster** is displayed in the waiting room area of the clinic. The Put Prevention Into Practice logo helps to inform patients that preventive care is a priority for the clinic staff.

The **Adult Preventive Care Timeline Chart** depicts preventive care in a timeline format. It is a quick reference source for clinicians and an educational tool for patients when displayed in the exam room. Preventive practices that all major authorities agree are needed at specific ages are denoted by dark-colored bars, whereas those preventive practices recommended by only some major authorities are denoted by light-colored bars.

> In Practice
> In Harlem, the poster inadvertently was used as an empowering tool by the patients. After reading the poster and recognizing a prevention need, patients were able to remind their clinicians about it and consequently received more preventive care.

The **Diabetes Poster**, which reminds patients to "take off their shoes" if they are diabetic, is also helpful when posted in the exam room. This poster serves as a cue to the clinician to ask the patient about diabetes and to examine the feet. Other such posters can also help to inform the patient about what preventive services are recommended/available. (The Diabetes Poster is available from the TDH Diabetes Program, (512) 458-7490)

Personal Health Guide

Purpose

The Personal Health Guide (PHG) serves as a tool to educate and empower patients in preventive care and risk behavior change.

General Instructions

The Personal Health Guide is a pocket-size booklet that serves as a preventive care tracking document. The PHG helps the patient and provider to assess risk factors and to plan an individualized schedule of preventive services. The importance of each major preventive service is clearly and simply explained and the booklet has a tracking log for preventive services. The patient should be encouraged to make note of when preventive services are due and to request these services as needed. Further instructions on how to use the PHG in counseling of patients can be found in Chapter Seven of this guide.

> In Practice
> Many patients view the Personal Health Guide as a mini-textbook for health topics and share the books with friends and family.

Procedures for Use

1. Explain the purpose of the PHG to the patient (the PHG is best used in conjunction with the Health Risk Profile).

2. Some sections of the PHG are for the patient to read and complete. Based on identified risk areas, assist the patient in completing the other sections under the specific risk factors.

3. Have the patient read and review the important information on each page. Reinforce the health messages provided and assist the patient in setting goals for behavior change, if appropriate.

4. Provide other health education literature as needed.

5. Assist the patient in finding resources for other health issues identified.

6. Encourage the patient to bring the PHG to subsequent visits.

7. Ask the returning patient if he/she brought the book back, if it is being used, and how.

8. Address identified risks and goals at each visit and update the PHG.

9. Reinforce positive behavior changes, however small.